Project Summary

In the fall of 2002, the Rappahannock Rapidan Health District (the District), the public health authority of a five-county planning region in north-central Virginia, began planning for the mass vaccination and/or prophylaxis of its residents. Plans indicate that an estimated 1600 persons are needed to operate eight emergency vaccination centers necessary to ensure the safe delivery of vaccine to all residents within an adequate time period to protect and save lives.

The District spearheaded collaboration among local hospitals, medical practices, county governments and first responders. Coordination was needed on a number of issues, but the need for a trained and ready corps of volunteers to assist in public health disaster response emerged as a priority. To meet this need, the region will establish a Rappahannock-Rapidan Medical Reserve Corps (RRMRC). The RRMRC will be a community-based, sustainable, volunteer-led organization of caring individuals that can provide competent clinical services during emergencies. Additionally, in periods of calm, it can provide added support to public health.

Project Narrative

I. Background. Public health agencies around the country have begun enhancing their capabilities to respond to large-scale emergencies. Due to the complexities of such a multi-disciplinary response, they will require resources they do not routinely have or use. This is especially true with staffing, where trained and licensed personnel are required to perform functions critical to controlling the spread of disease, such as providing vaccinations or medications. This staffing shortfall is particularly notable in rural communities where limited numbers of clinicians choose to settle and practice. To be as ready as possible for a public health emergency, the District is leading a community wide effort to establish a medical reserve corps.

Location. The Rappahannock-Rapidan Health District operates though a cooperative agreement between the state health department and the five local governments of Culpeper, Fauquier, Orange, Madison and Rappahannock counties. It is located east of the Blue Ridge Mountains in Virginia's north-central Piedmont region. The District has a population of 144,000 (2002 U.S. Census Bureau). These rural counties have developed diversified economies based on agriculture, heavy and light manufacturing, trade, and services (See Annex A; "Map of the Rappahannock-Rapidan Region")

The Rappahannock, Rapidan and North Anna Rivers flow through the District. The region is prone to severe summer storms that can spawn tornados. Flooding is also a serious problem following winters with heavy snows and during periods of excess precipitation, such as when thunder storm cells stall over the area. In 1995, this phenomenon led to major flash flooding in Madison County causing numerous casualties and millions of dollars of property damage. Hurricanes Camille (1969), Agnes (1972), David (1979) Gloria (1985) Fran (1996) Bonnie (1998) and Floyd (1999) all caused significant flooding in portions of the District.

In addition to natural hazards, the potential for manmade incidents is high. Interstate 66, US Routes 15, 29, 33, 211, & 522 and Virginia Routes 3, 28 & 231 transit the district. These major highways carry a high volume of commercial truck traffic. The Norfolk Southern and CSX maintain approximately 100 miles of railroad track that carry freight and passenger trains. Both transport industrial chemicals with the potential for a spill leading to a serious HAZMAT incident. Several factories maintain large propane gas tanks, and there is a major junction of natural gas pipelines in western Culpeper County. In addition, there are a number of facilities that could be the target of a terrorist attack. The federal government maintains three sensitive communications and training facilities in Fauquier County. The Society for International Financial Telecommunications (SWIFT), a global consortium of banks, brokerages and other financial companies that manage international financial transactions, maintains a data storage

center in Culpeper County. Culpeper is also home to a former Federal Reserve nuclear protection bunker used for many years as a back-up center for clearing financial transactions and storing data. Additionally, the Dominion Power Company's North Anna Nuclear Power Station has the potential to scatter radioactive material into Orange County.

The proximity of the District to the National Capital Region, connected by the main thoroughfares heading west (I-66) and south (US Route 29) from Washington DC, presents the potential for a mass influx of thousands of evacuees into the area during a crisis. Their presence would require an effective and coordinated response, seriously straining existing resources.

Responsible Organization. The District provides services that promote and protect the public health from five offices located throughout the District. Clinics are provided for women's health, maternity, well child, immunizations, sexually transmitted diseases and nutrition services. They are operated by a professional staff of fifteen public health nurses, four certified nurse practitioners, a physician, a dentist, two dental assistants and three nutritionists. In addition, a program for the healthy development of families is operated by three registered nurses and six support staff. The environmental health professional staff includes fifteen specialists. They ensure proper sanitary conditions at places serving food to the public, monitor zoonotic diseases, and inspect septic systems and private wells. There are 26 additional support staff. The District is well regarded by the community for these services. In 2003 an epidemiologist and an emergency planner were hired to enhance the District's response capabilities.

Linkages within Our Community. The District has a long history of bringing together community partners to solve regional health problems. As threats of bioterroroism have become more evident, the District has stepped up to assume a leadership role in the region's preparation for biological and chemical disasters.

The District has made great progress in solidifying linkages with the community that facilitate its emergency response capabilities. Intensive efforts began last winter as district officials began planning for mass vaccination and prophylaxis. The planning process highlighted personnel, equipment, facility and supplies the region would need. Continuous dialog was established with county administrators, emergency managers, law enforcement departments, fire companies, emergency medical service units, hospitals, school systems, volunteer organizations, social service agencies, professional societies and others to coordinate emergency plans. (Annex B; "Community Liaison Efforts" provides a listing of the District's EP& R outreach activities since January 2003.)

In January 2003, the District invited representatives of the region's first responder groups to a meeting to discuss smallpox disease and vaccination. Support from the community was strong and the District Health Director identified a need and willingness for increased collaboration both in planning for and response to community-wide emergencies. In response to this, the Rappahannock-Rapidan Emergency Preparedness Task Force (the Task Force) was formed. The Task Force is composed of public health managers, county officials, five county emergency managers, the first responder community, the two regional hospitals, the two Red Cross Chapters in the district, the regional planning commission, the regional emergency medical services council and the regional representatives of the state Department of Emergency Management and HAZMAT team. (See Annex C; "Members of the Rappahannock-Rapidan Emergency Preparedness Task Force")

This was the first time that these groups, so important to a coordinated emergency response effort, were brought together as a regularly meeting body. This level of coordination among five separate jurisdictions is a tremendous strength in a rural area. This is especially critical because the counties lie along major highways leading from the National Capitol Region. During a major emergency, none of these counties would be able to solely respond to an influx

of evacuees. This task force has been instrumental in coordinating the District's emergency plans with existing county emergency plans and procedures; it will continue to play a leading role in the coordination of district wide emergency management initiatives.

The Task Force has been meeting monthly since March. Meetings have dealt with pre and post-event smallpox vaccination; plans for dispensing medications to the community in an emergency; education of the community on bioterrorism issues; outreach to citizens to volunteer during an emergency; chemical decontamination; and preparation for biologic and chemical terrorism drills planned for August, September, and October 2003. In June, the members of the Task Force voted to assume the role of a Citizens Corps Council for the five-county region to facilitate additional programs focusing on citizen involvement, such as the MRC. The Task Force is now officially registered as a Citizens Corps Council on the Citizens Corps website.

II. Objectives. During a large-scale emergency, localities need to be prepared to sustain response activities for up to 72 hours until state and/or federal personnel and resources arrive to assist. The threats this area faces, including bioterrorism, require that reliably trained volunteers, some with clinical expertise, be ready to join in these efforts. The District is leading the effort to establish the Rappahannock-Rapidan Medical Reserve Corps (RRMRC) to ensure this happens. Additionally, this effort will support resources to ensure a stronger public health infrastructure in the community.

By establishing a functioning RRMRC, the District will meet the following objectives:

1) Sustaining a community-based structure that strengthens the region's medical response capacity.
2) Establish a corps with a constant census of approximately 2000 trained and ready individuals to serve throughout the region during a public health emergency.
3) Ensure sufficient funding for ongoing support of the RRMRC.

4) Develop initiatives in which RRMRC volunteers act to support the public health infrastructure during non-emergency situations.

III. Summary of Existing Relevant Community Resources. Within the five counties that comprise the District, there are many resources of people, equipment and expertise that could be deployed during an emergency response. The District has strong working relationships with many agencies due to its long history of community-based participation and its leadership role with the Task Force.

First, there are numerous emergency response entities in the region. If needed in a public health crisis, agreements have been made for the District to request these resources through county Emergency Operation Centers (EOCs). Each county in the district has a sheriff's department; there are also four local police departments. There are 18 volunteer fire departments, 16 volunteer fire and rescue companies, one paid rescue squad and three volunteer rescue squads. Culpeper County sponsors a Community Emergency Response Team (CERT). Several fire companies have basic level HAZMAT equipment and training. The closest operations level HAZMAT teams are located in Winchester and Fredericksburg, Virginia, counties adjoining the east and west of the district.

Each county in the District has developed an emergency response plan in accordance with state law and using guidance from the Virginia Department of Emergency Management. Response for large-scale emergencies is coordinated through five county emergency managers. Two of the five of these emergency managers are volunteers. During declared local or state emergencies, the emergency managers report to the chairs of the county boards of supervisors, who by state law act as directors of emergency management for their counties. The director of emergency management will make the decision, based on a recommendation from the emergency manager, to activate the county EOC. Once activated, the county EOC will

coordinate response operations, directing all local assets available (such as first responders, utilities, public works departments, social services, public health, Red Cross). The county EOC will coordinate with neighboring jurisdictions and request additional state assets from the state EOC as needed. All five counties have mutual aid agreements and have a long history of assisting each other in emergencies. If the emergency response requires a public health component, the District Health Director will go to the county EOC most impacted by the emergency or the Director may establish the District's own EOC to coordinate a district wide response. District liaison officers have been identified and will be dispatched to the county and hospital EOCs if the latter occurs. All county EOCs, as well as the District EOC and the hospitals, will use an incident command system to manage response. All have undergone training in use of this system.

Additionally, the Office of Culpeper Emergency Services maintains a roster of 600 persons willing to work in an emergency, including a subset of emergency medical technicians (EMTs). The agency has agreed to coordinate recruitment of these persons for emergency public health response. The Virginia State Police Division Two Headquarters is located in Culpeper, as is the seventh district administrator's office of the Virginia Department of Transportation. The assets of these agencies can be requested through the Virginia EOC. The Virginia Department of Emergency Management's regional coordinator is also located in Culpeper.

Second, there are two regional hospitals, both major employers in the region. Fauquier Hospital has 86 beds and Culpeper Regional Hospital has 70 beds. In the past year, both facilities have formed emergency planning committees and have drafted plans and procedures for a large-scale disease outbreak. District Emergency Planning & Response (EP&R) staff are members of these committees and have participated in developing and exercising their emergency plans. The hospitals have purchased equipment and developed training for emergency response procedures. Hospital plans include recall of employees and volunteers to

assist in mass vaccination efforts at specified hospital facilities. The District is currently organizing efforts to train these staff in vaccination using bifurcated needles.

Third, there are several volunteer organizations. Two American Red Cross chapters, have jurisdictions that coincide with the District's, the Fauquier County Chapter and the Culpeper-Madison County Chapter. They both have active disaster action teams and respond to hundreds of disasters each year, mostly single family home fires. The district Emergency Planner is on the Board of Directors for the Culpeper-Madison County Chapter. Additionally, the Piedmont United Way, located in Culpeper, operates a volunteer placement program, First Call for Help.

Fourth, the Culpeper Department of Social Services has agreed to make available their 180 employees to the RRMRC for emergency response.

To augment all of these resources, the Task Force will draw upon licensed professionals in the community to make up the heart of the RRMRC. Virginia Department of Health Professions' data indicate that the following numbers of health specialists are licensed and practice within the five counties of the District: 120 Physicians, 69 Dentists, 57 Pharmacists, 49 Veterinarians, 60 Nurse Practitioners, 802 Registered Nurses, 395 Licensed Practical Nurses, 318 Emergency Medical Technicians, and 92 Mental Health Professionals.

Using these data and other sources, the District has built a database of over 250 clinicians (physicians, physician assistants and/or nurse practitioners), which includes routine and emergency notification information. This facilitates contact with not only the physicians but their auxiliary staff.

IV. The Organizational Structure, Local Leadership and Key Staff of the RRMRC. As the main body in coordinating emergency management issues for the region, the Task Force will provide oversight for the establishment and operation of the RRMRC. The District EP&R personnel will staff the organization and assume the initial responsibilities of managing the

RRMRC until its senior officers are installed. The District will provide the RRMRC office space and house all records. Once fully established, the RRMRC will be organized as a separate community-based 501(C) 3 not-for-profit corporation (See Annex D; Profiles of Initial Key Leaders).

The Task Force will appoint a 12-member Board of Directors. It will consist of officials from the District, the United Way, Red Cross Chapters, the hospitals, and emergency management. This will provide broad experience in volunteer programs, health care issues and emergency response. RRMRC general membership will vote to nominate individuals for this board. The list of nominees will be forwarded to the Task Force, which will formally appoint the members of the Board of Directors. The District Health Director and District Emergency Planner will be permanent members of the Board. Board members will serve two-year terms and will be able to succeed themselves. The RRMRC will have five officers, a Director, Deputy Director for Operations, Deputy Director for Administration and Finance, a Chief Medical Officer and a Volunteer Recruitment and Development Officer. These officers will be appointed by the Board of Directors. The Board will also appoint other officers as they deem necessary. RRMRC Officers will serve terms of two years and may succeed themselves. The RRMRC Director and both Deputy Directors will also serve on the Board of Directors.

During periods of normal operations, the officers will build, organize and train the volunteers for an emergency response. The Director will be responsible for the overall progress in achieving operational readiness. The Deputy Director for Operations (DDO) will be responsible for developing operational plans and for developing training programs and exercise scenarios. The Deputy Director for Administration and Finance (DDAF) will be responsible for maintaining appropriate records, minutes, logs and other documents as required and serve as treasurer. The DDAF will also oversee the RRMRC's credentialing program, ensuring that each volunteer is readily identifiable. The Chief Medical Officer (CMO) will ensure that quality

standards of care are maintained and will serve as the liaison between the RRMRC and the District's healthcare community, including hospitals, medical practices, mental health professionals, and mortuary services. The Volunteer Recruitment and Development Officer will lead the effort in bringing new volunteers of all skill levels into the RRMRC.

During an emergency, RRMRC will respond to an activation order from a county or the District EOC. That order would require the RRMRC director to begin a recall notice. The notice would be transmitted to the RRMRC membership using various methods, including telephonic notification, broadcast e-mail, website postings and local radio stations. Several counties are considering purchasing Reverse 911 systems, which might also be employed. The officers of the RRMRC would report to the activating jurisdiction's EOC and assume their duties in the operations section. (See Annex E; "Proposed Organization of the Rappahannock-Rapidan Medical Reserve Corps during a Normal Operating Environment and when Activated for an Emergency Response").

When activated, the RRMRC officers will report to the operations staff officer in the activated EOC. The DDO will maintain volunteer recall efforts and integrate spontaneous volunteers into the relief effort. The DDAF will be responsible for proper credentialing as well as tracking necessary financial expenditures. The Chief Medical Officer will take charge of staffing assignments.

The RRMRC is an important *additional* asset upon which a county (or the District) EOC may call. They would be activated when more personnel are needed for emergency support functions (ESF) associated with public health. The Federal Emergency Management Agency organizes all disaster response activities into 12 categories. The eighth category (ESF- 8) provides assistance for public health and medical care needs. All major disasters require some form of public health response. Examples include controlling epidemics due to bioterrorism, dirty flood waters, contaminated food or natural occurrence. ESF-8 functions also include the

issuance of necessary health advisories, providing trained medical staff at public shelters, coordinating patient surge capacity with local hospitals and governments, coordinating emergency mortuary services, insect and rodent control, and inspecting disaster-relief food and water supplies. RRMRC volunteers could be called upon to assist in any of these functions. RRMRC will not replace or compete with any existing agency. The RRMRC will only expand on the ability of the Health District and hospitals to perform their ESF-8 functions. The RRMRC fills a critical gap in providing additional trained and licensed personnel to work in medication and distribution clinics or other areas during an emergency. The RRMRC leadership will work closely through the EOC with the Health District Staff, Red Cross chapters, and hospital officials. Potential questions and concerns about the RRMRC will be addressed through the Task Force, the forum established for discussing and coordinating these issues.

V. Strategy & Plans. Please see Annex F for a table of goals, strategies, objectives, timeline, and evaluation methods. A narrative of the plan's goals is provided below.

1. Determine the need for a medical reserve corps in the region. (Completion date: April 2003)

The need for trained volunteers to enhance medical response capacity became apparent during the initial EP&R planning conducted by District staff. Plans for mass vaccination against smallpox and for the distribution of the SNS support this.

2. Educating Stakeholders, Community Leaders and the Public on the Need for a Medical Reserve Corps (Completion Date: August 2003)

Initial outreach through newspaper articles and talks to targeted groups generated an understanding of the need to enhance medical response capabilities in the community. It quickly became clear that more resources and structure were necessary to organize and train a large

volunteer corps. No single agency in the district had the capability to take this task on alone. Stakeholders and community leaders, including the emergency managers, hospitals, United Way and Red Cross chapters agreed to pool their resources and looked to the District as the leading agency in this effort.

3. Maintain Forum of Community Partners Needed for Coordinated Emergency Response and Support of a Vital Medical Reserve Corps (Completion Date: Ongoing)

The region has an established Emergency Preparedness Task Force that meets on a regular basis and is comprised of all necessary agencies. The Task Force members clearly understand and support the idea of an RRMRC. The District will work closely with the Task Force to implement this plan.

4. Identify and Recruit Leaders for the Medical Reserve Corps (Completion Date: January 2004)

At its August 2003 meeting, the Task Force will appoint the initial Board members. Other professionals, such as attorneys, accountants and communications professionals, will also be recruited for the RRMRC Board of Directors. The Board will identify and recruit local leaders to serve as the RRMRC's officers. They will be selected based on their knowledge of public health, medical practice, emergency management, and organizational development.

5. Establish an Organizational Structure for the RRMRC (Completion Date: 2nd Quarter 2004)

The plan for establishing the organizational structure, the District's role in that plan and the nature of that structure, is detailed above in Section IV.

6. Recruit volunteers (Completion Date: Full corps in place by January 2006)

Recruiting Health Care Professionals Recruiting these professionals is critical to the success of the MRC. It is estimated that 48 clinicians, 236 nurses and/or nursing assistants, and 16 pharmacists are required for mass vaccination. The RRMRC will also aggressively seek 154 Emergency Medical Technicians (EMTs) to become members as under Virginia law, they will also be authorized to administer vaccinations during a declared emergency.

To recruit qualified, licensed volunteers, the Volunteer Recruitment and Development Officer will personally call on all of the physicians' offices, hospital staff organizations and pharmacies in the district over a two-year period. To augment these efforts, the RRMRC will implement a proactive marketing campaign promoting volunteering by health professionals. Elements of the campaign include a well-known physician in each county acting as a spokesperson for the RRMRC.

The campaign will feature promotional materials developed with the theme "Operation Volunteer: Give it a Shot!" A mix of media will be used to promote this message, including direct marketing, ads in eight local newspapers and in hospital and government newsletters, ads and PSAs on local radio stations, an interactive website, and cable public access programming. The VDH's regional Public Information Officer has agreed to advise the RRMRC on communications strategies for this campaign. A former spokesperson for the Virginia State Police, she is highly regarded in this region's emergency management community.

District staff, as well as the RRMRC leadership, will also continue to seek and accept public speaking opportunities to inform the community about the RRMRC's role in emergency response and the critical need for volunteers. District staff members have already met and discussed volunteer needs with the Fauquier Medical Society, Culpeper Hospital medical staff, Fauquier Hospital Smallpox Team, Rappahannock Rapidan Home Health and Hospice Care,

Culpeper Medical Association, Fauquier Medical Managers Group, and Fauquier School Advisory Board.

Overcoming the Barrier of Liability Issues in Recruiting Health Care Professionals Under Virginia law, there are a number of potential sources of immunity for health professionals acting in a voluntary capacity. The "Good Samaritan" statute provides a series of instances in which people voluntarily performing certain types of assistance, in good faith, are immune from civil liability. In addition under a "charitable immunity" doctrine interpreted from other sections of Virginia law, voluntary health workers are protected from civil liability for acts or omissions that do not result from gross negligence or willful misconduct. With these protections in place, malpractice concerns should not be a barrier to recruitment efforts. This information will be prominent in all marketing efforts.

Recruiting Non-Clinically Trained Volunteers While the law requires the presence of licensed individuals to perform certain functions, such as giving vaccinations, an effective response effort to a public health emergency will also require many non-clinically trained volunteers that can perform such functions as greeting clients, handing out forms, assisting with client flow through the clinics, and managing supplies. To meet the need for the approximately 800 non-clinically trained volunteers, the District will approach faith-based organizations, non-profit groups, civic clubs and other organizations with active memberships to participate in the RRMRC. These groups have the capability of bringing blocs of members who can quickly be assigned tasks. This approach takes advantage of important community resources with an existing organizational structure. The Culpeper Department of Social Services has recruited faith-based leaders as Board members and this group has agreed to act as a liaison in these efforts.

7. Training and Exercises (Completion Date: Ongoing)

Turning a group of 2000 volunteers into a cohesive entity ready to respond will be accomplished through a practical program of training and exercises. While recruiting new volunteers will be the main program focus for Years One and Two, training and exercises will be the focus for Year Three and beyond. Job descriptions have been developed for the major clinical functions needed in mass vaccination or prophylaxis efforts. (See Annex G; Volunteer Staffing Needs and Job Descriptions for the Rappahannock-Rapidan Health District)

All volunteers will be required to take an orientation course that will introduce them to the MRC concept, explain the role of the RRMRC during a response, and provide an overview of emergency clinic operations. Initially, this course will be designed as a 90-minute presentation that will be offered four times a year, during evenings or weekend hours, by the District staff. All RRMRC volunteers will be required to complete this training every two years. RRMRC volunteers will also be required to have basic life support and cardiopulmonary resuscitation (CPR) training as well as basic first aid training. The two American Red Cross chapters in the District and the two hospitals will provide these courses to RRMRC volunteers in special sessions.

Specialized training will be developed as needed. For example, volunteers for epidemiological contact tracing teams will be required to attend a 2-hour course on basic epidemiological principles, and nurses and emergency medical technicians will be given training in the use of bifurcated needles to administer the smallpox vaccination. Refresher training in these areas will be given immediately prior to opening of smallpox vaccination clinics.

Realistic training exercises will be held twice a year that will enable volunteers to test their skills. These exercises will be coordinated with county emergency managers so that any

number of response capabilities, not just the RRMRC, can be exercised. In addition to activation drills, various exercises might include clinic operations, chemical decontamination, disease surveillance, emergency communications and search and rescue.

8. Fundraising (Completion Date: Ongoing)

The Board will select a finance subcommittee that will develop fundraising plans and strategies. Funding for the development of this concept will be greater in initial years. A huge investment of time is needed to build a new sense of commitment to voluntarism by licensed healthcare professionals in our community. The Task Force feels that to overcome this hurdle, one-on-one recruitment will be required. To ensure this critical step is achieved, funding will be allocated for a paid Volunteer Recruitment and Development Officer. This paid position will enhance regional readiness by more effectively managing the volunteer recruitment effort and allowing the RRMRC to become operational more quickly. Other start-up costs will include office equipment, incorporation fees and credentialing materials.

After establishment of the corps, operational costs will decrease but will continue. To meet these requirements, the Board will conduct a person-to-person solicitation among business leaders in the community. The District will continue to staff and house the organization on a long-term basis.

VI. Summary of Community Partnerships. An important factor in the long term success of the RRMRC is the strength of its ties throughout the region. Emergency response is a multi-disciplined undertaking. The District has begun much of the liaison work for building the community support for this initiative. (See Annex H; Letters of Support). Ensuring this support is demonstrated through the following efforts:

1) The Task Force brings together the important players, local governments, county emergency managers, first responders, hospitals, and local Red Cross Chapters. These

groups have agreed to play a role in the RRMRC, whether it is by providing volunteer management expertise, training or other support

2) District staff members make numerous presentations to the medical community and to first responders about issues related to public health emergency preparedness and response. A targeted outreach and media campaign was recently completed for smallpox preparedness.
3) District staff members serve on hospital bioterrorism and infection control committees, school health advisory committees, and community-wide partnerships for the identification and intervention of at-risk women and children and other community-wide health needs;
4) District personnel promote general public health awareness through presentations to community groups and through various media outlets.

The next step will be to not just involve, but fully engage other school systems, departments of social services, churches and faith based organizations, civic clubs, chambers of commerce, the private sector and others to participate in the RRMRC. The initial meetings with these groups have already begun. For example, district staff recently met with the Culpeper Department of Social Services Board of Directors and with the Rappahannock Superintendent of Schools and received their whole-hearted support in recruiting their employees to volunteer in emergency response efforts.

In the months ahead, the Task Force, District, RRMRC leadership and other partners will begin hosting a series of "town meetings" in the five counties. These meetings will help define the roles that different groups, which have not necessarily been active in emergency management before, can play through the RRMRC. If the RRMRC is not always suitable for an activity, other Citizen Corps programs, such as CERT or Neighborhood Watch, will be discussed. In addition, other partners such as the Red Cross or hospitals will be on hand to discuss their programs.

Input from these groups will be vital in developing roles that the RRMRC may play in non-emergency times. There are many community health issues that need to be addressed; it would be a waste of resources and talent to build a corps of ready volunteers, but only to use them in an emergency. Some examples of planned RRMRC non-emergency activities include participation at health screenings, community health education, and outreach to non-English speaking communities.

VII. Measuring the RRMRC's Progress. The process of establishing and developing the RRMRC will be regularly reviewed to ensure that objectives are being met in a timely fashion and that the RRMRC will be fully functional in the event of an emergency. The Task Force, IOB and RRMRC Board of Directors will receive regular reports at its meetings on what objectives have been successfully accomplished and the status of all on-going efforts. In addition, the volunteer recruitment and development officer will be responsible for collecting and reporting to the Task Force the following information every two months:

1) total number of volunteers recruited
2) ratio of recruited volunteers by specialty (doctors, registered nurses, translators, etc.) to the total number of volunteers required
3) number and percentages of volunteers that have completed the required training

Through this and other information, the RRMRC officers, directors and the Task Force will determine if recruitment and training efforts are successful or if those efforts need to be adjusted. (Please refer again to Annex F)

VIII. Sharing the RRMRC's Best Practices. In the voluntary sector, the MRC is a new concept that will be adapted across America to fit local and regional procedures, practices and customs. Through time, local leaders and sponsoring organizations will learn the best way to

structure MRC programs and activities in their communities. These "lessons learned" are invaluable to organizers of new MRCs and sharing them contributes to the overall readiness of each community and our nation to respond to an emergency. The leadership of the RRMRC will be charged with developing a record of its best practices, which will include, but is not limited to, organizational structure, building community support, volunteer recruitment and financial development. The RRMRC will issue best practice reports to the Task Force and to OSG on an annual basis, or more frequently as required. Through the EP&R directorate of the Virginia Department of Health, the District will also establish a clearinghouse of best practices information for MRCs from across Virginia and its neighboring states.

IX. Plans for Sustaining the RRMRC in the Years Following Federal Funding.

Following the three years of federal funding, the RRMRC will have established a structure for this effort and will secure other revenue streams to meet its ongoing operational costs. The organization's practices will be delineated, and plans and materials will in be place. The Volunteer Recruitment and Development Officer's role will evolve to a coordination function rather that of cultivating voluntarism among healthcare professionals. At that point it will be manageable as a voluntary position. District personnel will continue to staff the organization. Specific duties will be included in the District Emergency Planner's job description.

After the initial start-up years, current projections are that operational expenses will total about $15,000 a year. The RRMRC will commence a financial development program to raise the required amount of money. RRMRC volunteers with fundraising experience will participate. As a 501(c) 3 non-profit entity, the RRMRC will be eligible to compete for various grants as well as accept tax deductible donations from companies and private citizens. Three years is adequate time for donor prospecting, identification and solicitation. The five local county

governments will also be also approached by the District to support the RRMRC through an annual authorization.